| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345551 | A. BUILDING _____ B. WING _____ | C 07/17/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRUITTHEALTH-CAROLINA POINT | 5935 MOUNT SINAI ROAD DURHAM, NC 27705 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, and record/document review the facility failed to provide the eating assistance as ordered by the physician for 1 of 2 sampled residents (Resident #5) assessed as dependent upon the facility for eating assistance. The findings include:<br><br>Resident #5 was admitted to the facility on 5/27/2014 with the diagnoses of Cerebral Vascular Accident with Aphasia, Dysphagia, Hypertension, Atrial fibrillation, and Blindness. The last Minimum Data Set (MDS) Assessment completed on 6/9/2015 coded the resident as requiring extensive assistance with eating. He was also coded on the MDS assessment as having short and long term memory problems as well as being highly impaired for vision. The care plan last reviewed on 6/9/2015 listed one of his problems as, "Potential for alteration in nutrition and hydration due to current disease process." The interventions on the care plan did not state the resident was to be assisted with eating. One of the interventions did state that he was to be offered beverages before each meal. A speech pathology report dated 10/13/2014 stated that the resident presented, "with mild oropharyngeal dysphagia." Recommendations were made at that time by the speech pathologist. Physician's | F 312 | This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.<br><br>Corrective action will be accomplished for the resident found to have been affected by the deficient practice:<br><br>Resident #5 has been re-evaluated by Speech and Occupational therapy and has been admitted to case load. Facility is following current physician order while therapy is evaluating and treating.<br><br>Corrective Action for Those with Potential to be affected.<br><br>All residents with orders for assistance with feeding has a potential to be affected by the alleged deficient practice. The Unit | 8/8/15 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/31/2015

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| F 312 | Continued From page 1<br>orders for July 2015 stated, "Diet: Mechanical soft consistency with ground meats, thin liquids, double portion entree, resident should be fed all meals, alternate liquids and solids, should be seated up right for all meals, make sure patients mouth is clear before leaving patient."<br><br>Observations were made of the lunch meal for Resident #5 on 7/17/2015 beginning at 12:30 PM. Resident #5 was sitting in his wheelchair with a bed side table in front of him. At 12:35 PM a nursing assistant brought a lunch tray to Resident #5 and set up the tray in front of him. The nursing assistant helped the resident to get a mouthful of food and then left the room to assist with passing out the other trays. At 12:40 PM the nursing assistant again stopped in the resident's room and assisted the resident with another mouthful of food and then she left the room again. The physician's order to make sure patient's mouth is clear before leaving patient was not followed. At 12:45 PM the Director of Nursing (DON) came into the room and asked the resident if he needed help. The DON sat with the resident as he lifted the food into his own mouth. At 12:52 PM the DON remained with the resident and told him to slow down as he fed himself. When the resident stopped feeding himself, the DON offered him a spoonful of green beans and then a spoonful of fish. She then offered pie to the resident. At 12:55 PM the resident was offered a drink of fluid by the DON. At 1:00 PM the resident refused any more food or liquids from the DON. The physician's order to alternate liquids and solids was not followed.<br><br>At 1:05 PM on 7/17/2015 the nursing assistant assigned to the resident was interviewed. She stated that Resident #5 needed help drinking | F 312 | Manager and the Unit Coordinator will audit 100% of the medical records for orders requiring assist with feeding. The C NA care Guides will be updated by Unit Manager and Unit Coordinator if needed with current orders. The audit and updates of care plans will be completed by 8/7/15<br><br>Measures put into place or systemic changes made to ensure that the deficient practice will not occur:<br><br>The following systemic changes will be implemented to prevent re-occurrence. The Clinical Competency Coordinator began in-service on 7/21/15 the nursing staff on feeding assistance , and this training will emphasize the importance of using the C NA Care Guides that will instruct staff as to the resident¿s needs.<br><br>Residents with a decline in eating will be referred to therapy for evaluation, treatment and any instructions to the staff. Instructions from the Therapy department will be reviewed by the Unit Manager and the Unit coordinator to ensure the instructions are added to the C NA Care guide and the Resident Care plan. The Unit Manger and the Unit Coordinator will review all orders requiring assistance with feeding to ensure all orders are added to C NA Care Guides and care plans.<br><br>Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and | |

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| F 312 | Continued From page 2<br>fluids and he needed someone to encourage him to eat. She stated, "We feed him and sometimes he feeds himself." The DON stated on 7/17/2015 at 1:20 PM that Resident #5 ate 25% of the meal. She also stated that she went into the room to assist him because he was picking up pie with his hand.<br><br>On 7/17/2015 at 3:30 PM the DON additionally stated that the resident would get a referral to speech therapy for evaluation. She said the physician's orders for Resident #5 would either be discontinued or updated with his current needs. | F 312 | sustained:<br><br>The unit manager, Director of Health Services and staff nurses will observe residents requiring assistance with meals for breakfast, Lunch and dinner, to document compliance weekly for four weeks, then monthly for 2 months. All concerns will be corrected immediately and the staff will be re-educated at that time. The results of observations will be discussed in QA monthly for 3 months and then re-evaluated for continued compliance. | |